

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-024172

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1002 Registrar's No. 3069

STATE FILE NUMBER

FILED JUN 17 1963

1. PLACE OF DEATH

a. COUNTY

Jackson

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN

Kansas City

Length of stay in the
2 yrs.c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION

7209 Washington

Inside Limits
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Missouri

b. COUNTY

Jackson

c. CITY
OR
TOWN

Lee's Summit

Inside Limits
Yes ☐ No ☐d. STREET
ADDRESS

(If outside, give location)

Reside on Farm
Yes ☐ No ☐3. NAME OF DECEASED
(Type or print)

First

Middle

Last

Carl

Virgil

Biggs

4. DATE
OF
DEATH

Month

Day

Year

May-28-1963

5. SEX

Male

6. COLOR OR RACE

White

7. Married ☐ Never Married ☐Widowed ☒ Divorced ☐

8. DATE OF BIRTH

4-29-1880

9. AGE (last birthday)

83

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HR

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Contractor

10b. KIND OF BUSINESS OR INDUSTRY

Self

11. BIRTHPLACE (City and state or country)

Maumond City, Mo.

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

Ross Biggs

13b. MOTHER'S MAIDEN NAME

Nancy Menow

14. NAME OF HUSBAND OR WIFE

Florence Biggs

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of)

No

16. SOCIAL SECURITY NO.

7209 Washington

17. INFORMANT

Mr. Iney Biggs

Address

7209 Washington

18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIAC INSUFFICIENCY

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

BRONCHIAL ASTHMA

DUE TO (c)

SENILITY - HBP

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)PART III. If deceased was female was
there a pregnancy in last 90 days.☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☐

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURYHour Month, Day, Year
a.m.
p.m.20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from SEPT 5-1962 to MAY 28 63 and last saw her alive on DEC 1962

Death occurred at 6:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

Womale Funeral Home Mrs. H.P.M. 5-31-63

Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF David S. Long, MEDICAL CERTIFICATION

VS 300
Rev. 4/59

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27004
X

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9443X

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13

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed W. C. Rine

Licensed Embalmer No. 4879

P. O. Address K. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.